

Health Clearance Form University of Tampa

TREATING PHYSICIAN, PA, APRN OR LICENSED MENTAL HEALTH
PROFESSIONALS QUESTIONNAIRE

Instructions:

This form is to be completed only by the treating physician, psychiatrist, licensed psychologist or other mental health professional. Please respond to the questions listed below and attach a brief statement of recommendation for medical clearance for re-enrollment **on your office letterhead.**

Please return to:

**Sean McLawhorn, MS, LMHC
Health Clearance Committee
Clinical Case Manager
401 W. Kennedy Blvd.
Box 116F
Tampa, Florida 33606.**

You may also confidentially fax this form to (813) 258-7413.

On occasion, a student, for medical/psychological reasons, chooses to take a leave of absence and/or is prevented from re-enrollment at The University of Tampa through a Spartan Support Program hold. This procedure is employed only after all available University resources have been pursued in an attempt to reduce or remedy the student's medical/psychological issue while still enrolled. Therefore, it is the policy of The University of Tampa, that any student prevented from re-enrollment for medical/psychological reasons in this or any other institution must have this form completed by a physician or mental health professional and submitted to The University of Tampa for approval by the Health Clearance Committee before the student will be permitted to re-enroll.

If the problem is medical, a physician must complete the form. If the problem is psychological, a psychiatrist, licensed psychologist or other licensed mental health professional must complete the form. If a student seeks an evaluation from a community mental health clinic, it is understood that he or she may be seen by psychologists, social workers, or counselors with the option of being evaluated by a psychiatrist for medication of further diagnosis. If the student has been hospitalized, personnel on the hospital treatment team may appropriately complete this questionnaire. **In any event, the form must be completed and signed by a physician (if medical) or by a psychiatrist, licensed psychologist, licensed therapist with a certification in addictions or other treating mental health professional (if psychological) and the evaluation must consist of a minimum of eight sessions and/or medication checks. If substance abuse dependency treatment was warranted, it is recommended that the student demonstrate successful completion of treatment and successful sobriety and/or abstinence from other drugs for a minimum of 1 full year.**

1. Full name of student & ID # _____
Student's current email address _____
Student's current phone number _____

2. a. Please provide professional credentials including professional license number and state of licensure.

b. Did you provide the treatment for the above-named student? ___ Yes ___ No

c. How many treatment sessions have you provided for the student (relating to this matter)? ____

d. When did the treatment commence? _____ Conclude? _____ Ongoing? _____

e. Has the above-named student completed treatment? ___ Yes ___ No

3. Briefly describe the student's problems as you see them and include all diagnoses, if applicable. Please feel free to attach a separate page if necessary.

4. Have you referred the student for continuing treatment? ___ Yes ___ No

If yes, please indicate the name, address, and phone number of the individual or agency. You may wish to consult with the Dickey Health and Wellness Center regarding the availability and appropriateness of referral resources in the community or you may choose to have the student consult the Dickey Health and Wellness Center for referrals.

Please keep in mind that The University of Tampa Dickey Health and Wellness Center is a SHORT-TERM, solution-based center and may not be used as a referral for long-term psychotherapy. Students needing long-term psychotherapy are referred to a community mental health professional. Students are responsible for providing their own transportation to these appointments and are required to confirm proof of treatment through informed consent between the community provider and the Dickey Health and Wellness Center.

5. What would continuing treatment for this student entail? If substance abuse is an issue, please share aftercare plan. Attach additional sheets if necessary.

6. If you referred the student for continuing treatment, do you believe the student would be able to function appropriately as a student at the University of Tampa without continued treatment? ___ Yes ___ No

7. Please comment on the student's current functioning.

8. a. Do you consider that the student presently or in the reasonably foreseeable future may be a threat to their own life or the lives of others? ___ Yes ___ No

b. Is the student currently exhibiting any harmful or self-harming behaviors? ___ Yes ___ No
Comments:

9. Does the student require medication in order to function effectively? ___ Yes ___ No
If yes, please describe medication treatment program and how the student will access medications.

10. Do you think this student is capable of carrying a full academic load (12 – 18 credit hours)? ___ Yes ___ No

11. In which type of housing would you recommend the student live?

___ a. Campus residence halls.

___ b. Off-campus private housing.

___ c. Live at home or with extended family and commute.

Please explain the reasons for your recommendation.

12. To your knowledge, are the parents and/or legal guardians of the student aware of the issue(s) for which you have provided treatment? ____ Yes ____ No

13. Other comments:

Signature of Treating Professional

Date